PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council held Tuesday, September 27, 2005, 10:00 a.m., at the Massachusetts Department of Public Health, 250 Washington Street, Boston, Massachusetts. Public Health Council Members present were: Chair Paul Cote, Jr., Commissioner, Department of Public Health, Ms. Phyllis Cudmore, Mr. Manthala George, Jr., Ms. Maureen Pompeo (arrived at 10:12 a.m.), Mr. Albert Sherman (arrived at 10:15 a.m.), Ms. Janet Slemenda, Mr. Gaylord Thayer, Jr., and Dr. Martin Williams with Dr.Thomas Sterne absent. Also in attendance was Attorney Donna Levin, General Counsel.

Chair Cote, announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance. In addition, Chair Cote noted that docket item 2b should read, "Approval of reappointments to the consulting medical staff of Western Massachusetts Hospital, letter of September 14, 2005."

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Associate Commissioner Sally Fogerty, Center for Community Health Services; Mr. Alan Holmlund, Suicide Prevention Coordinator; Ms. Holly Hackman, Injury Epidemiologist, Injury Prevention and Control; Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control; Ms. Cathleen McElligott, Director, Office of Rural Health; Ms. Joan Gorga, Acting Director, Bernard Plovnick, Consulting Analyst, Determination of Need Program; and Deputy General Counsels: Attorney Madeline Piper and Attorney Sondra Korman, Office of the General Counsel.

RECORDS:

After consideration, upon motion made and duly seconded, it was voted (unanimously) [Ms. Pompeo and Mr. Sherman not present to vote] to approve the Records of the Public Health Council Meeting of July 26, 2005.

PERSONNEL ACTIONS:

In letters dated September 13, 2005, Syed Rahman, MD, Director, Department of Medicine and Daniel L. Breslin, MD, Director, Department of Psychiatry, Tewksbury Hospital, Tewksbury, recommended approval of appointments and reappointments to the various medical and allied health staffs of Tewksbury Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) [Ms. Pompeo and Mr. Sherman not present to vote] That, in accordance with the recommendation of the above noted Department Directors of Tewksbury Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following appointments and reappointments to the various medical and allied health staffs of Tewksbury Hospital be approved for the period of September 1, 2005 to September 1, 2007.

APPOINTMENTS:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Alan Schonberger, PhD	3977	Provisional Allied/Psychology
Andrew Aldridge, MD	76759	Provisional Active/Psychiatry

REAPPOINTMENTS:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Charles Pu, MD	73771	Affiliate
Predeep Reddy, MD	75118	Affiliate/Consultant
Bruce Price, MD	49559	Consultant
Jonathan Hertz, MD	212535	Affiliate
Josephine Albano, MD	37000	Active
Christopher Huvos, PsyD	3614	Allied
Deborah Turiano, MD	57944	Consultant

In a letter dated September 14, 2005, Blake Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of reappointments to the consulting medical staff of Western Massachusetts Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) [Ms. Pompeo and Mr. Sherman not present to vote] That, in accordance with the recommendation of the Director of Western Massachusetts Hospital, Westfield, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following reappointments to the consulting staff of Western Massachusetts Hospital be approved:

REAPPOINTMENTS:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Stanley Glazer, MD	Dermatology	35736
Andrew Boraski, OD	Optometry	3125

In a letter dated September 12, 2005, Paul Romary, Executive Director, Lemuel Shattuck Hospital, Jamaica Plain, recommended approval of reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously) [Ms. Pompeo and Mr. Sherman not present to vote] That, in accordance with recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, chapter 17, section 6, the following reappointments to the various medical and allied health staffs of Lemuel Shattuck Hospital be approved:

REAPPOINTMENTS:	MASS. LICENSE NO.:	STATUS/SPECIALTY:
Shreekant Chopra, MD	39069	Active/Internal Medicine; Nephrology
Kenneth Pariser, MD	40490	Active/Internal Medicine; Rheumatology
Gregory Clark, MD	47684	Active/Psychiatry
Yevgeniy Arshanskiy, MD	204156	Consultant/Radiology
Sanjeev Bagga, MD	216581	Consultant/Radiology
David Tesini, DMD	12919	Consultant/Dentistry
Betty Morgan, CNS	148706	Allied Health Professional
Emily Robinson, NP	216235	Allied Health Professional

Note: For the record, Council Member Maureen Pompeo arrived at the meeting in time for the staff presentation. Council Member Albert Sherman arrived at few minutes later during the presentation.

STAFF PRESENTATION:

"SUICIDE AND SELF-INFLICTED INJURIES IN MASSACHUSETTS: AN OVERVIEW OF THE DATA AND PREVENTION EFFORTS", BY SALLY FOGERTY, ASSOCIATE COMMISSIONER, CENTER FOR COMMUNITY HEALTH SERVICES, ALAN HOLMLUND, SUICIDE PREVENTION COORDINATOR, HOLLY HACKMAN, INJURY EPIDEMIOLOGIST, INJURY PREVENTION AND CONTROL:

Ms. Sally Fogerty, Associate Commissioner, Center for Community Health, made introductory remarks followed by Ms. Holly Hackman, Injury Epidemiologist, Injury Prevention and Control. Ms. Hackman said in part, "…The State data presented here was derived from multiple sources, including death certificate data, the Massachusetts Violent Death Reporting System, which is a new database in our state, which I will describe further in a moment, and Massachusetts Emergency Department databases, which include information on non-fatal injuries, survey findings from the Massachusetts Behavioral Risk Factor Surveillance System, which is a random, telephone survey of Massachusetts adults 18 years and over, and the Massachusetts Risk Behavior Survey, an anonymous written survey used at public high schools in Massachusetts, and administered by the Massachusetts Department of Education."

Ms. Hackman continued, "First, examining suicide in relationship to other health problems; it is important to be aware that suicide is among the leading causes of death for many age groups, both in Massachusetts and nationally. In 2003, in Massachusetts, there were more than three times as many suicides as homicides in our residents. Nearly twice the number of suicides as AIDS deaths, and two and a half times as many acute care hospitalizations for self-inflicted injuries and for assault related injury. Self-inflicted injuries, I want to point out, are injuries inflicted by a person in an attempt to cause self-harm, and include, but are not limited to suicide attempts. Examination of the trend in homicide and suicide numbers in Massachusetts over the last ten years, for which we have data, indicates that suicide has consistently been two to three times higher than homicides in Massachusetts. While in recent years the number of suicides has been stable, there has been a slight decline in the overall annual number since the mid-nineties."

"In the field of injury", stated Ms. Hackman, "We often use what is known as the injury pyramid. It demonstrates that the injury deaths, which are found at the top, are just the tip of a much greater public health problem. Non-fatal injuries, which range in severity, affect a significantly larger number of individuals. As you will note, in 2003, there were 423 completed suicides, over 3800 hospitalizations for self-inflicted injury, over 6300 emergency department visits for self-inflicted injury, and the lowest tier of this pyramid represents the extent of the problem, which is not captured by our health system. In the Massachusetts adult population, 18 years of age and older, there were an estimated 28,500 additional individuals who attempted suicide and did not seek medical treatment and 139,000 individuals in our state who seriously considered suicide. Among high school students, 21% of males and 35% of females reported feeling so sad or hopeless that they stopped some usual activities for two weeks or more during the prior 12 months, and one in

five female students, and nearly 13% of male students reported they seriously considered suicide in the past twelve months and overall, both sexes combined, 8.4% of our high school youth reported attempted suicide."

Ms. Hackman noted some further statistics during her slide presentation:

- The largest number of deaths occur in middle age individuals with nearly one in four suicides in 2003, or 103 among individuals age 35 to 44 years of age.

- Males have higher rates of suicide than females in every age group, and overall rates among males were three times that of females. And among females, you will see a different peak than that of males. Female rates of suicide peak among 35 to54 year olds, and among males there are two peaks. The highest peak in among individuals age 85 and over, with rates over two times that of individuals 75 to 84, and the number of suicides in this population was ten. A secondary peak among males is middles age among 35 to 54 year olds, which is similar to that seen in females.

- Females have a higher rate of non-fatal, self-inflicted injury hospitalizations than males in all age groups combined and specifically among age groups ten to sixty-four, when males actually start to have higher rates.

- Two year average annual suicide rates by race and ethnicity indicate higher crude rates among White non-Hispanics and lowest rates among the Hispanic population. Eight suicides occurred among other race and ethnic categories, including Cape Verdian and Native Americans. Hospitalization rates for self-injury by race and ethnicity indicate that the highest rates are among Hispanics, compared with other race and ethnic groups.

- Overall, the leading method of suicide in Massachusetts is suffocation or hanging. This differs from the national leading method which is firearms. Thirty-eight percent of suicides in Massachusetts in 2003 were completed by suffocation or hanging. Poison agents are the leading cause used by females and hanging is the leading agent for males. Fire arms are much more prevalent in their use among males than females for suicide.

- The leading methods differ by age groups. Hanging and suffocation are used proportionally more than firearms and poisoning among younger age groups; and firearms are proportionately used more than hanging among individuals 75 years and older.

- Eighty percent of non-fatal self-inflicted injuries (hospitalizations) are caused by poisoning. Suffocation and firearms are usually lethal.

In closing, Ms. Hackman stated, "Additional information surrounding the circumstances of suicides and non-fatal injuries is important to effectively target our prevention efforts, and I will acknowledge at the outset that we are in the very early stages of surveillance in tracking the underlying circumstances leading to these events. One system for collecting this sort of in depth surveillance information is the National Violent Death Reporting System, also known as NVDRS. NVDRS collects detailed data on suicides and homicides from multiple sources, in order to develop

improved public health approaches for prevention. This database is being developed here in Massachusetts and in 16 other participating states through a cooperative agreement with the CDC. This system is expected to be eventually expanded to all fifty states. It follows a model of surveillance which has been highly effective in reducing other forms of injury deaths in our country.

Preliminary findings from the first year of data, 2003, indicate that, of those suicide victims where circumstance information was known, nearly one quarter had a substance abuse or alcohol problem. One in five had an intimate partner problem, including victimization and/or perpetration, 17 percent had prior suicide attempts, and 31 percent of the victims tested for alcohol were found to be positive. The location of these suicides, three quarters of them occur in a house or apartment, and of the poison agents used in suicides by poisoning, anti-depressants was the leading agent associated with suicide by poisoning, responsible for 29 percent of these deaths, and the second leading agent was carbon monoxide.

What else do we know about those who attempt? From the Youth Risk Behavior Survey, which I discussed before, we know that students are more at risk for suicidal attempt if they are gay or lesbian, live in an urban district, are recent immigrants, or are disabled. Furthermore, according to the Youth Risk Behavior Survey, in 1997, nearly 28% of the youths reported a past history of sexual assault, reported a suicide attempt and, among our entire population, research estimates that 13% of Massachusetts rape victims attempt suicide at some point in their lives, compared with 1% of the non-victims of crime."

Mr. Alan Holmlund, Suicide Prevention Coordinator, added, "The Department of Public Health has partnered with the Department of Mental Health and the Massachusetts Coalition for Suicide Prevention to establish a strategic plan for suicide prevention in the Commonwealth. This plan, along with the data you have just seen, guides the activities of the Suicide Prevention Program. Most suicides are preventable through multi-faceted intervention approach. Interventions that reduce risk factors and strengthen protective factors are effective in reducing suicide. The study of suicide is a relatively recent phenomenon, however, since the early 1980s, much has been learned…Psychological autopsies of completed suicides find that up to 90 percent have a diagnostic mental illness, including substance abuse."

Mr. Holmlund continued, "Other studies highlight the large number of people who need mental health treatment but never receive it, and it is useful to learn that most people communicate their suicidal intent either directly or indirectly before acting. Some intervention strategies that are used to prevent suicide are: 'means restriction'. An example would be the architectural barriers on the Cape Cod bridges that have virtually eliminated them as a means. Another might be gatekeeper training, which is the education of teachers, elder care givers, EMTs, and so forth, to recognize suicide warning signs, how to intervene, and how to obtain help. Support services are often directed towards survivors and, by this, we mean people who have lost a loved one to suicide. Preliminary results from the 2005 Behavioral Risk Factor Surveillance Survey indicated that there are some nine hundred thousand adults in Massachusetts who have lost someone close to them by suicide."

Mr. Holmlund noted some continuing education activities that the Department conducts: seminars targeting gatekeepers such as funeral directors, school administrators, and an annual statewide suicide prevention conference that last year attracted over five hundred people; training for

gatekeepers and skills training for mental health and substance abuse professionals. He said, "for the second year, the Department has purchased and distributed the 'Signs of Suicide Prevention Program' for high schools, and this year we are providing National Depression Screening Day kits for 30 Massachusetts colleges to be used on October 6th, National Depression Screening Day. National Depression Screening Day is an activity endorsed by the Department collaboratively with the Department of Mental Health. This year, through the RFR (Request for Responses) process, we are soliciting community responses for the provision of suicide prevention services."

"In the future", Mr. Holmlund said, "the program was awarded one of the 13 Youth Suicide Prevention State Grants from the Substance Abuse and Mental Health Services Administration. We will use that money to provide suicide prevention training for the Department of Social Services foster parents and case workers, and family intervention services for families with a suicidal youth involved with the Department of Youth Services. We want to expand our data gathering and analysis capability. We currently have a very active Suicide Prevention Coalition statewide, but see the need to develop regional, more grassroots coalitions. Lastly, we will continue to implement prevention strategies, shaped by the data on suicide and self-injury that is specific to the residents of the Commonwealth."

MISCELLANEOUS: REQUEST FOR ADOPTION OF MAGISTRATE'S RECOMMENDED DECISION AS THE FINAL DECISION OF THE DEPARTMENT IN THE MATTER OF EMERGENCY MEDICAL TECHNICIAN JOHN A. MILLER:

Attorney Madeline Grace Piper, Deputy General Counsel, Department of Public Health, presented the Magistrate's Recommended Decision in the matter of John A. Miller to the Council. Attorney Piper said, "…I am before you today to ask you to adopt and affirm a decision, a tentative decision, handed down by the Administrative Magistrate at the Division of Administrative Law Appeals, where the Department has revoked Mr. Miller's EMT certification, and the sanction is a permanent revocation until Mr. Miller provides the Department with written proof from a certified mental health professional that he does not pose a risk to the public. This sanction is consistent with the Department's CORI regulations, even though it has been the longstanding policy of OEMS to permanently revoke certification on the basis of conviction of a crime against children. In this case, Mr. Miller is given an opportunity to sort of rehabilitate himself and reinstate himself."

Attorney Piper noted that Mr. Miller was convicted of two crimes against a child, assault and battery on a child and a threat to commit a crime, to commit murder against that same child, who was his stepdaughter. A brief discussed ensued by the Council. Attorney Sondra Korman, Deputy General Counsel, Department of Public Health, stepped forward to clarify some matters to the Council. Attorney Korman said, "The CORI Regulations define a qualified mental health professional specifically as a licensed social worker, a psychiatrist, psychologist, a clinical social worker, who has at least 1000 hours in the assessment, treatment and consultation concerning individuals with behaviors that present a risk of harm to others in the setting." It was also noted that a letter from a supervising probation officer is also an option for Mr. Miller to present to the Department for reinstatement of his certification.

Mr. John A. Miller appeared before the Council. He said in part, "The question I have had through this whole thing is that, what the law states is that crimes committed in the performance of your

duties, and at no time was any of this in the performance of my duties, it was an ugly divorce case, and she took the opportunity of me disciplining my child to file charges against me. And at no time have I ever had a complaint against me or any problems in the performance of my duties, which is clearly stated in the law, yet they are turning this into a performance of duty issue and it has never been."

Attorney Piper responded, "DPH's action was based on two separate and independent grounds. DPH, through its Office of Emergency Medical Services, acted following confirmation of a complaint alleging that Mr. Miller had been convicted of assault and battery of a juvenile and threats to a juvenile, to wit murder. These convictions formed the basis of the revocation on the grounds that Mr. Miller violated 105 CMR 170.940 (E), which states that revocation may be based on "commission of any criminal offense relating to the performance of duties including any conviction relating to controlled substance violations." DPH also alleged that Mr. Miller violated 105 CMR 170.940(C), which states that revocation may be based on "failure to exercise reasonable care, judgment, knowledge, or ability in the performance of duties…The fact that Mr. Miller was convicted of crimes against a juvenile was uncontested. The OEMS policy of revoking EMT certification when the EMT is convicted of committing crimes against juveniles is a consistently applied and longstanding policy. The policy is based on the principle that an emergency medical system, and the EMTs who operate within it, must have the public's trust in order to perform successfully. A crime against juveniles violates the public trust. The Magistrate also noted that an EMTs duties include intimate examination and assessment of the patient. She found that an EMT, in performing his duties, may be alone in the back of an ambulance with an unconscious patient, and an EMT who is tending to a juvenile has the right to prevent the juvenile's parents from being present in the ambulance. It was noted that prior cases by the Department, similar to this have been permanent revocation of an EMTs license but due to the CORI Regulations in effect now, Mr. Miller has a chance to rehabilitate himself."

Discussion continued Council Member Thayer made a recommendation that the mental health professional selected by Mr. Miller be satisfactory to the Department. The other members agreed to this amendment. Mr. Miller stated that the charges were regarded as misdemeanor and not considered felonies at the time that he pled guilty to them. He also said, "I am not doubting the fact that I disciplined my child. There is no doubt in that, and I did hit her. I hit her on the side of her arm, not what the police officer's report says. And I didn't even fight that because my lawyer said that you are going to go in there and say that you did this." Council Member Sherman noted his concern that Mr. Miller had no lawyer to represent him. Mr. Miller stated that he could not afford one.

Attorney Donna Levine, General Counsel for the Department of Public Health, stated, "What we do is, we see a factual situation, which we have here. He was represented by Counsel. He pled guilty to these two convictions. We are charged with protecting the public's health and safety in this regard, in certifying EMTs. We undertook all the due process that is required here. We took this before an independent Magistrate….And, at this point we are bringing you a tentative decision of this independent counsel which, in the opinion of the Office of General Counsel and the attorneys who brought this action, and the independent Magistrate, what happened here in these convictions meets the grounds for this revocation. He has the right to appeal this matter in Superior Court. However, there is precedent here so that the appeal will probably be unsuccessful. He also has an

opportunity to have an evaluation done, which he could have had done already while all this was pending, so that he would have the minimum of thirty days revocation and then he would be back with that evaluation, performing as an EMT."

A brief discussion ensued. Mr. Miller was asked by Council Member George if he could continue as a Firefighter without the EMT status. Mr. Miller said, "If I lose my certification, I will lose my job." Mr. Miller said that he worked in a small town (East Brookfield, MA) and he had no union protection.

Chair Cote said, "I would like to request adoption of the Magistrate's Recommended Decision as amended today." After consideration, upon motion made and duly seconded, it was voted: (Chair Cote, Ms. Cudmore, Mr. George, Jr., Ms. Pompeo, Ms. Slemenda, Mr. Thayer, Jr., and Dr. Williams in favor; Mr. Sherman abstaining (Dr. Sterne absent) to **Approve and Adopt the Magistrate's Recommended Decision and impose the sanction of revocation of John A. Miller's EMT certification for a minimum of 30 days and until Mr. Miller has provided the Department of Public Health (DPH) with an acceptable written assessment from either his supervising probation officer or a qualified mental health professional that he does not pose an unacceptable risk to the public. The Council added an amendment that states: "the mental health professional is to be satisfactory to the Department of Public Health**." A copy of the material presented to the Council is attached and made a part of this record as **Exhibit No. 14,826**.

REGULATIONS:

REQUEST FOR APPROVAL TO PROMULGATE AMENDMENT TO 105 CMR 130.000 (HOSPITAL LICENSURE REGULATIONS):

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, made introductory remarks, followed by Ms. Cathleen McElligott, Director, Office of Rural Health, Center for Community Health Services. Ms. McElligott said, "We are here today for your final approval of our emergency regulations that we were before you in July for, for the amendment of the Hospital Licensure Regulations for Rural Hospital Definition, and we do need that in order to maintain our three critical access hospitals, their federal Medicare Certification to be critical access hospitals, as well as they are working on converting Athol Memorial Hospital right now to a critical access hospital designation."

Staff's memorandum to the Council explained, "The purpose of this memorandum is to seek the Council's approval to finalize an emergency amendment to 105 CMR 130.000, hospital licensure regulations. The Department previously promulgated the amendment on an emergency basis on July 26, 2005, to ensure that Massachusetts retains the authority to have its own, state-specific, definition of 'rural hospital' as the term applies to eligibility for the certification of small hospitals in rural communities as Medicare Critical Access Hospitals (CAHs)."

Staff noted, "The amendment is needed to ensure that three hospitals in rural communities (Fairview Hospital-Great Barrington, Martha's Vineyard Hospital, and Nantucket Cottage Hospital) are able to maintain their current federal status as a Medicare CAH for purposes of receiving cost-based federal Medicare reimbursement. It will also allow one other eligible small hospital (Athol Memorial

Hospital), which is considering CAH conversion, to seek this designation this fall by the impending federal deadline. The ability to qualify for a CAH designation is essential because CAHs receive enhanced, cost-based federal Medicare reimbursement to assist with maintaining the viability of local health care services in the more remote and less densely populated rural communities. Since the inception of the Medicare Rural Hospital Flexibility Program in 2000, all states, including Massachusetts, have been able to adopt a definition of 'rural' in their State Plan that is most appropriate for their jurisdictions. However, provisions of the federal Medicare Modernization Act of 2003 being implemented are sun-setting states' authority to maintain a state-specific definition of 'rural' for use in certifying Medicare CAHs unless there is a state definition codified in state law and regulation. As a result, without this language, Massachusetts will be forced to use a new, more restrictive, federal definition of 'a rural area', and one of the hospitals currently designated as a Medicare Critical Access Hospitals (Fairview Hospital of Great Barrington) will lose its CAH designation and its cost-based federal Medicare reimbursement. The loss of federal Medicare reimbursement for Fairview Hospital would put it at serious risk for closure, thus limiting access to healthcare for rural communities in its area and resulting in losses to the local rural workforce and the local rural economy….This regulation change will ensure that the small rural Massachusetts hospitals currently certified as Medicare CAHs continue to be designated as such, and will also allow for one additional hospital in a rural community to become certified within the next few months."

It was noted that the Department held a public hearing on August 30, 2005 which no one attended. The Department received two letters of support from the Massachusetts Hospital Association and Fairview Hospital of Berkshire Health Systems.

After consideration, upon motion made and duly seconded, it was voted: (unanimously) to approve the **Request for Approval to Promulgate Amendment to 105 CMR 130.000 (Hospital Licensure Regulations)**; that a copy be forwarded to the Secretary of the Commonwealth; and that a copy of the amendment be attached and made a part of this record as **Exhibit No. 14,827**. As approved, this amendment adds the definition to be used for eligibility as a Medicare Critical Access Hospital: "Rural Hospital," means an acute care hospital licensed under M.G.L.c.111,§51, which: (1) has 50 or fewer licensed beds and based on the published United States Census 2000 data of the US Census Bureau is in a city or town whose population is less than 20,000 and is located within a city, town, service area, or County whose population density is less than or equal to 500 people per square mile and which applies for such a designation; or (2) is a hospital designated as a Critical Access Hospital as of July 1, 2005 by the Federal Department of Health and Human Services in accordance with federal regulations and state requirements.

REQUEST FINAL PROMULGATION OF AMENDMENT TO 105 CMR 100.000, GOVERNING FILING DAYS FOR APPLICATIONS FOR INNOVATIVE SERVICES:

Ms. Joan Gorga, Acting Director, Determination of Need Program, presented the amendment to 105 CMR.100.000 to the Council. Ms. Gorga said, "I am here this morning to request Council's action on final promulgation of the proposed amendments to change the filing date for Neonatal Intensive Care Unit applications from August 2005 to August 2007. The amendment is necessary because the Department is considering testimony from the hearings on the Maternal and Newborn sections of the Hospital Licensure Regulations, which will be finalized in the winter. The licensure regulations

were not completed in time for the August filing date of the NICU application and, therefore, the date needed to be extended. Moving the filing date to 2007 will allow the hospitals to evaluate the licensing regulations and to assess their interest and capability in providing the services at the levels established in the regulations before preparing the DoN application. Staff, therefore, asks that you approve the final promulgation of the amendment to move the NICU filing date to August 2007."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the **Request for Final Promulgation of Amendment to 105 CMR 100.000, Governing Filing Days for Applications for Innovative Services and New Technology;** that a copy be forwarded to the Secretary of the Commonwealth; and that a copy be attached and made a part of this record as **Exhibit No. 14,828**. This amendment to 105 CMR 100.302 (F) changes the Neonatal Intensive Care Unit Filing Date from August 2005 to August 2007. Thereafter the filing day for such applications shall be the first business day of February and August.

DETERMINATION OF NEED PROGRAM:

COMPLIANCE MEMORANDUM: PREVIOUSLY APPROVED DON PROJECT NO-4-4886 OF SHIELDS IMAGING OF MASSACHUSETTS, LLC – REQUEST TO ADD HEALTHALLIANCE HOSPITAL, BURBANK CAMPUS AS A FIFTH HOST SITE TO THE MOBILE POSITRON EMISSION TOMOGRAPHY (PET) SERVICE:

Ms. Joan Gorga, Acting Director, Determination of Need Program, presented Project Application No. 4-4886 of Shields Health Care to the Council. Ms. Gorga said, "This morning I am presenting for your action a request for a significant change filed by Shields Imaging of Massachusettss, LLC in the previously approved Project No. 4-4886 for a mobile PET Service. The change involves the addition of the Burbank campus of HealthAlliance Hospital as a fifth host site to provide one day per week of mobile PET service. Currently, three days per week of mobile service are allocated to UMass Memorial Medical Center in Worcester. One of these days, Saturday of each week, would be allocated to HealthAlliance at the Burbank campus. HealthAlliance is a UMass affiliate and a consortium member of UMass. This is not an increase in capacity since it does not add days, but reallocates days. In addition, the HealthAlliance population was included in the demand calculation for the project when it was approved in 2002. This action also has no effect on the recent approval of the Central Mass. Imaging Center since the volume of scans performed at the Worcester site was shown to have little or no impact on the recently approved scanner. In conclusion, staff recommends approval of this request to add the Burbank campus as a fifth site."

Staff's memorandum to the Council noted in part, "The holder states that the addition of Burbank campus as a service location will not substantially change the population served by the PET unit since both the UMMMC site and the Burbank site are in the same HSA and referrals from the Fitchburg and northern Worcester County areas were included in the demand calculation for the approved DoN Project No. 4-4886. In addition, there is no duplication with the recently approved DoN Project No. 2-4906. The Staff Summary for that project indicates that the number of scans performed at the Worcester site on the mobile unit would have little or no impact on the ability of the scanner in Project 2-4906 to maintain the minimum volume required by the Guidelines. The holder states that there will be no substantial capital expenditures as a result of the addition of the Burbank campus location as a host site. Costs associated with the UMMMC site will be reduced

proportionately and reallocated to the Burbank site. In conclusion, staff finds that proposed amendment to DoN Project No. 4-4886 satisfies the requirements for significant changes set forth at 105 CMR 100.753(A) and 100.756."

After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the Request by **Previously Approved DoN Project No. 4-4886 of Shields Imaging of Massachusetts, LLC to add HealthAlliance Hospital, Burbank campus** as a fifth host site to the mobile Positron Emission Tomography (PET) Service. This amendment is subject to the following condition:

1. All conditions attached to the original and amended approval of Project No. 4-4886 shall remain in effect.

CATEGORY 1 APPLICATIONS (COMPARABLE):

PROJECT APPLICATION NO. 4-3A60 OF LAHEY CLINIC PET SERVICES, LLC. TO PROVIDE POSITRON EMISSION TOMOGRAPHY (PET) SERVICES THROUGH ACQUISITION OF A FIXED PET/CT BODY SCANNER:

PROJECT APPLICATION NO. 5-3A62 OF SOUTHCOAST HOSPITALS GROUP TO PROVIDE POSITRON EMISSION TOMOGRAPHY (PET) SERVICES THROUGH ACQUISITION OF A MOBILE PET/CT BODY SCANNER:

PROJECT APPLICATION NO. 4-3A63 OF MOUNT AUBURN AND WINCHESTER HOSPITALS TO PROVIDE POSITRON EMISSION TOMOGRAPHY (PET) SERVICES THROUGH ACQUISITION OF A MOBILE PET/CT SCANNER:

Ms. Joan Gorga, Acting Director, Determination of Need Program, presented the comparable PET applications to the Council. She said, "This morning Staff is pleased to present to you applications for three hospitals seeking to provide Positron Emission Tomography or PET Services. Staff has reviewed this most recent batch of applications based on the methodology introduced to you last month, which had been developed for the first batch of applications. We continue to use utilization rates and projection data based on the 2004 and 2005 experience of Massachusetts hospitals with DoN approved PET services. The three comparable applications for PET services, which will be presented this morning, are Lahey Clinic PET Services, Southcoast Hospitals Group, and a joint application of Mount Auburn and Winchester Hospitals. Because each one was reviewed and considered approvable, staff will present them individually and the Council will vote on them after all three reviews have been heard."

Ms. Gorga, presented the Lahey Clinic Application on behalf of Jere Page, Senior Analyst for the application, who was unable to attend the meeting. Ms. Gorga noted, "Lahey Clinic PET Services, LLC proposes to establish a PET service as Lahey Clinic Hospital in Burlington through an acquisition of a combination PET/CT body scanner. The recommended MCE is $3,221,825 in August 2003 dollars, which will be funded by a 20% equity contribution from Lahey and the remaining 80% will be financed through a capital lease from the vendor, GE Medical Systems. The project was reviewed against the review factors in the Determination of Need Guidelines for PET.

Based on the review, Staff determined that the proposed PET/CT service will exceed minimum volume requirements, as well as provide more accessible PET/CT services to patients in Lahey's primary service area. Staff also notes that, in response to the Community Initiatives requirement, Lahey has agreed to provide a total of $161,000 over five years to fund the following two programs: Planning Grants for Communities and Community Health Network Area (CHNA)15, to identify key healthcare issues, and then, through coalition building, implement community-wide plans to address these issues, followed by implementation grants to the CHNA communities that have developed successful plans; and, two, provide funding to support the activity's Critical Mass, a statewide coalition to eliminate health disparities. In conclusion, Staff recommends approval with conditions listed in the staff summary."

Mr. Bernard Plovnick, Consulting Analyst, Determination of Need Program, presented the Southcoast Hospitals Group application to the Council. Mr. Plovnick said, "Southcoast Hospitals Group is seeking the Council's approval today to become a provider of PET services. Southcoast serves Southeastern Massachusetts and Eastern Rhode Island from its three hospital campuses, Charlton Memorial Hospital of Fall River, Saint Luke's Hospital of New Bedford, and Tobey Hospital of Wareham. Collectively, the Southcoast Hospitals operate a total of 722 licensed acute care beds. Southcoast proposed to acquire a mobile PET/CT scanner that will operate on site at all three hospital campuses. The proposed and recommended maximum capital expenditure of $3,754,000 involves no construction, other than an electrical upgrade at each location. As detailed in the Staff Analysis, the Southcoast application meets or exceeds the minimum standards set forth in the DoN guidelines for Positron Emission scanners. Notably, applying the methodology utilized for projecting demand for PET scanning services in the analysis of previous applications to the Southcoast case mix for cancer and cardiac patients, Staff estimated an annual demand of 2,942 PET scans, well in excess of the 1,250 set as a minimum threshold by the guidelines. Additional volume is also expected to come from PET scans used in the diagnosis of Alzheimer's Disease, a newly approved application of PET for which a reasonable means for projecting demands is not currently available. Staff also found Southcoast to be in reasonable compliance with the provision of the guidelines, specifying that an applicant for PET services involves a tertiary teaching hospital. While not a medical center, Southcoast is a major provider of acute services. Ranking among the top five to ten among Massachusetts hospitals in annual discharges, Southcoast serves a population in excess of 400,000 persons, operates over 700 patient beds, and maintains a range of services comparable to that found in many tertiary hospitals."

"In addition", continued Mr. Plovnick, "Southcoast has contracted with the Chief of Nuclear Medicine from Dana Farber Cancer Institute to serve as Consultant Medical Director to its PET Clinical Oversight Committee. The recommended maximum capital expenditure of $3,754,000 will be financed through equity from existing unrestricted funds. Funding for Community Health Initiatives associated with this project will amount to $187,700 over five years, to support health promotion and disease prevention priorities to be determined by CHNA #25 and #26, in coordination with the Department's Office of Healthy Communities. In conclusion, Staff recommends approval of this project with conditions listed in the staff summary. The applicant is in full agreement with staff recommendation…"

Ms. Joan Gorga, Acting Director, Determination of Need Program, presented the co-applicants, Mount Auburn and Winchester Hospitals, seeking approval to provide PET services. Ms. Gorga stated, "The application was reviewed against the factors of the DoN Guidelines for PET, which include requirements on oversight, training, support services, and lack of discrimination of the ability to pay. The applicants are planning to share PET/CT service, and will each utilize the service an average of 2.5 days per week. All costs and expenses will be shared 50/50 by the co-applicants. The recommended MCE of the project is $4,153,223 which will be funded through a combination of equity and bond financing. In response to the community health initiatives requirement, Mount Auburn and Winchester have offered community initiatives with a total of $207,661 over five years for support of community prevention planning and projects in the service area of the hospital. In conclusion, Staff recommends approval of the application, Project No. 4-3863, with the conditions as indicated in the Staff Summary, which have been agreed to by the applicant. Staff would be glad to answer questions on the project. Representatives of the applicants are also here to answer questions."

A brief discussion ensued around the new applications of use for PET scanners such as cancer, cardiac and Alzheimer's and that everyone will probably want one in the future. Ms. Gorga responded in part, "…It is important to note that these applications and these demand projections are based on the institutional need of the facility. They are not based on facilities saying, we are going to have six hospitals coming to us with referral cases. They are based on their own patient population. That's why we feel that approving a number of them is not duplication because it is an institutional need for that patient population. It is based on the people who are there getting care at that hospital right now. Council Member Slemenda asked how the applicants' patient populations are presently receiving PET scans." The applicants' responded: Ms. Ellen Banach from Southcoast Hospitals Group said, "No, we do not currently have PET services available at our hospitals. The patients are referred elsewhere." Mr. Nicholas Dileso of Mount Auburn Hospital said, "We have the same situation as Southcoast. We do not have PET scanning services today. The patients are referred typically to Boston for those services". Dr. David Barrett of Lahey Clinic said, "We do not have a PET alliance at this time. The patients would have to go to an available PET scanner somewhere else. In fact, we would be sending them to multiple locations. The physician would refer them. Some patients would go without a PET scan…From my perspective the fear of not having an alternative, not being able to send the patient somewhere is one of the main motivators for us to have a PET scanner."

Dr. Paul Dreyer, Associate Commissioner, Center for Quality Assurance and Control, added, "To answer your question about whether we have an unduplicated count here, which I think is essentially what you are asking, the initial utilization rates, upon which we base the calculation, came from a time when hospitals were only serving their own patients. So that is, a given percentage of a hospital's cancer patients need a PET scan. A given percentage of a hospital's cardiac patients may need a PET scan. What the analysts are telling you is that we are looking at those hospitals'current patients to determine that they need a PET scan. So, either these patients don't get a PET scan or they have to go to some other hospital, to become some other hospital's patients, but the initial rates were based when there were no other hospitals for them to go to. So, the count is essentially unduplicated…" It was noted that three other applicants are in the queue, asking for PET scanners and would probably be heard by the Council this winter. Mr. Sherman made the motion for approval.

After consideration, upon motion made and duly seconded, it was voted: (unanimously) to approve all three comparable PET Applications: **Project Application No. 4-3A60 of Lahey Clinic PET Services, LLC** (a staff summary is attached and made a part of this record as **Exhibit No. 14,829**) To provide Positron Emission Tomography (PET) services through acquisition of a fixed PET/CT body scanner; **Project Application No. 5-3A62 of Southcoast Hospitals Group** (a staff summary is attached and made a part of this record as **Exhibit No. 14,830**) to provide Positron Emission Tomography (PET) services through acquisition of a mobile PET/CT body scanner; and **Project Application No. 4-3A63 of Mount Auburn and Winchester Hospitals**(a staff summary is attached and made a part of this record as **Exhibit No. 14,831**) to provide Positron Emission Tomography (PET) services through acquisition of a mobile PET/CT body scanner. These Determinations are subject to the following conditions:

Project Application No. 4-3A60 of Lahey Clinic PET Services, LLC:

1. Lahey Clinic shall accept the maximum capital expenditure of $3,221,825 (August 2003 dollars) as the final cost figure, except for those increases allowed pursuant to 105 CMR 100.751 and 100.752.

2. Lahey shall contribute 20% in equity ($644,365 in August 2003 dollars) toward the final approved MCE.

3. Lahey shall not consider ability to pay or insurance status in selecting or scheduling patients for PET/CT services.

4. Lahey shall provide a total of $161,091 over a five-year period or $32,218 per year to support the following community prevention planning and health promotion programs and projects in Lahey Clinic Hospital's service area.

    a. $27,385 per year over five years for a total of $136,927 will be provided through Community Health Network Area 15 ("CHNA 15") to support a community planning process throughout the CHNA 15 communities. The project will involve broad community involvement, a transparent allocation process, defined outcome measures and an evaluation plan. The CHNA 15 project will be achieved by offering Planning Grants for communities to identify key health issues and through coalition building implement community wide plans to address these issues. CHNA 15 will award three Planning Grants a year for three years followed in subsequent years by three Implementation Grants to CHNA 15 communities that have developed successful plans.

    b. $4,832 per year over five years for a total of $24,160 will be provided to Critical Mass, a statewide coalition to eliminate health disparities to support its activities as follows:

1. build a statewide membership, coordinate coalitions activities and develop training curricula and data collection methodologies,

2. organizational support to community/CHNA 15 efforts to eliminate health disparities through capacity building, training and data collection.

CHNA 15 and Critical Mass, in consultation with the Department's Office of Healthy Communities ("OHC"), will provide an annual report to Lahey and the Department/OHC regarding the disbursement of the funds contributed by Lahey. The annual report shall include a summary of the programs to which the funds have been applied and outcome measurement data for each program. This report will be issued no later than 90 days following the end of each 12-month period following the DoN Project implementation date. Lahey will disburse the funds to the fiscal agent(s) designated by CHNA 15 and Critical Mass.

Lahey will notify the OHC at least two weeks prior to the expected DoN project implementation date. The first payment will be due and payable not less than 30 days following the actual project implementation. Lahey will also file all reports as required by the Department.

5. With regards to its interpreter service, Lahey shall:

   - Develop a process for ensuring that patients with LEP have input into satisfaction surveys about overall hospital services and interpreter services and an analysis of the findings.

   - Submit the Annual Language Needs Assessment in December 2005 utilizing internal and external data. Involve community-based organizations in the Annual Needs Assessment (105 CMR 130.1103).

   - Explore the collection of ethnicity as a separate field from race in the hospital information system.

   A plan to address these interpreter service elements shall be submitted to OMH within 120 days of the DoN approval, and Lahey shall notify OMH of any substantial changes to its Interpreter Services Program. Also, Lahey shall follow recommended National Standards for Culturally and Linguistically Appropriate Services ("CLAS") in Health Care. In addition, Lahey will provide annual progress reports to OMH on the anniversary date of the DoN approval.

   Staff's recommendation was based on the following findings:

1. Lahey proposed to establish a Positron Emission Tomography (PET) service at Lahey Clinic Hospital in Burlington through acquisition of a combination of PET/Computerized Axial Tomography (CT) scanner.

2. The project meets the requirements of the health planning process consistent with the Guidelines for Positron Emission Tomography (Guidelines).

3. Lahey has demonstrated demand for the proposed PET/CT service, as discussed under the Health Care Requirements factor of the Staff Summary.

4. The project, with adherence to a certain condition, meets the operational objectives of the Guidelines.

5. The project meets the compliance standards of the Guidelines.

6. The recommended maximum capital expenditure of $3,221,825 (August 2003 dollars) is reasonable, based on a similar, previously approved project.

7. The revised and recommended incremental operating costs of $1,575,749 (August 2003 dollars) are reasonable for a PET/CT unit and related hospital construction to accommodate the unit.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit provisions of the Guidelines.

10. The project, with adherence to a certain condition, meets the community health service initiatives of the DoN Regulations.

11. The Mark R. Taylor Ten Taxpayer Group (TTG) registered in connection with the proposed project, but did not submit written comments or request a public hearing.

12. This project is one of three comparable applications filed by Lahey Clinic PET Services, LLC (Project No. 4-3A60), Southcoast Hospitals Group (Project No. 5-3A62) and Mount Auburn/Winchester Hospitals (Project No. 4-3A63). When considered alone, each of these three applications is capable of being approved, since each has demonstrated demand for PET/CT services. Therefore, a detailed comparability analysis was not undertaken since these three applications each meet all the review factors of the PET Guidelines.

Project Application No. 5-3A62 of SouthcoastHospitals Group:

1. Southcoast shall accept the maximum capital expenditure of $3,754,000 (August 2003 dollars) as the final cost figure, except for those increases allowed pursuant to 105 CMR 100.751 and 100.752.

2. Southcoast shall contribute 100% in equity ($3,754,000 in August 2003 dollars) toward the final approved MCE.

3. Southcoast shall not consider ability to pay or insurance status in selecting or scheduling patients for PET/CT services.

4. Southcoast has agreed to provide a total of $187,700 (August 2003 dollars) over five years to fund the following community health service initiatives:

    a. $16,270 per year over 5 years for a total of $81,350 will be provided to support programs and projects for disease prevention services and health promotion programs determined by Partners for a Healthier Community (CHNA 25) in consultation with the Department's Office of Healthy Communities (OHC) to address priority issues. CHNA 25 and the OHC agree that any grant or award of such funds will be to programs that agree to provide information concerning program accountability (including outcomes measurement) in the use of the funds.

    b. $16,270 per year over 5 years for a total of $81,350 will be provided to support programs and projects for disease prevention services and health promotion programs determined by the Greater New Bedford Health & Human Services Coalition (CHNA 26) in consultation with the Department's Office of Healthy Communities (OHC) to address priority issues. CHNA 26 and the OHC agree that any grant award of such funds will be to programs that agree to provide information concerning program accountability (including outcomes measurement) in the use of the funds.

    c. $5,000 per year over 5 years for a total of $25,000 will be provided to support statewide and regional programs and projects for Critical Mass, a statewide coalition to eliminate health disparities. Southcoast Hospitals Group will consult with OHC to determine the fiscal agent for this component.

    Funding for the initiatives set forth in paragraphs a,b, and c, above, will begin upon notification from Southcoast to the OHC at least 2 weeks prior to the expected date of implementation of the Project. Southcoast also shall file all reports as required by the Department. The first payment due hereunder will be due and payable not less than 30 days following the actual project implementation date.

    CHNA 25 and CHNA 26, in consultation with the OHC, will provide to Southcoast Hospitals Group an annual report of the disbursement of the funds contributed by Southcoast. The annual report shall include a summary of the programs to which the funds have been applied and outcomes measurement data for each program. This report shall be issued no later than 90 days following the end of each 12-month period following the project implementation date. At Southcoast's request, CHNA 25 and/or CHNA 26 and the OHC will meet with representatives of Southcoast to discuss the annual report.

5. With regards to its Medical Interpreter Service, Southcoast shall:

- Develop a reliable and valid system for the collection of self-reported race and ethnicity information from patients.

- Submit the Annual Language Needs Assessment required by 105 CMR 130.1103 utilizing internal and external data in January 2006 and involving community-based organizations in the process.

- Follow recommended National Standards for Culturally and Linguistically Appropriate Services ("CLAS") in Health Care.

Southcoast shall submit a plan to address these interpreter service items to OMH within 120 days of DoN approval and shall notify OMH of any substantial changes to its Interpreter Services Program. In addition, Southcoast shall provide annual progress reports to OMH on the anniversary date of the DoN approval.

Staff's recommendation was based on the following findings:

1. Southcoast proposes to establish a Positron Emission Tomography ("PET") service through acquisition of a mobile PET/Computerized Axial Tomography ("CT") scanner that will serve its three hospital campuses located in Fall River, New Bedford, and Wareham.

2. The project meets the requirements of the health planning process consistent with the Guidelines for Positron Emission Tomography ("Guidelines").

3. Southcoast has demonstrated demand for the proposed PET/CT service, as discussed under the Health Care Requirements factor of the staff summary.

4. The project, with adherence to a certain condition, meets the operational objectives of the Guidelines.

5. The project meets the compliance standards of the Guidelines.

6. The recommended maximum capital expenditure of $3,754,000 (August 2003 dollars) is reasonable, based upon similar, previously approved projects.

7. The recommended incremental operating costs of $2,018,000 (August 2003 dollars) are reasonable for a mobile PET/CT unit.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit provisions of the Guidelines.

10. The project, with adherence to a certain condition, meets the community health service initiatives of the DoN Regulations.

11. The Mark R. Taylor Ten-Taxpayer Group (TTG) registered in connection with the proposed project, but did not submit written comments or request a public hearing.

12. This project is one of three comparable applications filed by Southcoast Hospitals Group (Project No. 5-3A62), Mount Auburn/Winchester Hospitals (Project No. 4-3A63), and Lahey Clinic PET Services, LLC (Project No. 4-3A60). When considered alone, each of these three applications is capable of being approved, since each has demonstrated demand for PET/CT services. Therefore, a detailed comparability analysis was not undertaken since these three applications each meet all the review factors of the PET Guidelines.

Project Application No. 4-3A63 of Mount Auburn Hospital/Winchester Hospital:

1. Mt. Auburn/Winchester shall accept the maximum capital expenditure of $4,153,223 (August 2003 dollars) as the final cost figure, except for those increases allowed pursuant to 105 CMR 100.751 and 100.752.

2. Mt. Auburn/Winchester shall contribute 100% in equity for the Mt. Auburn Hospital portion of the MCE and 20% in equity for the Winchester portion of the MCE share ($396,300 in August 2003 dollars) toward the final approved MCE.

3. Mt. Auburn/Winchester shall not consider ability to pay or insurance status in selecting or scheduling patients for PET/CT services.

4. Mt. Auburn and Winchester Hospitals have agreed to provide 5% of the MCE, $108,586 from Winchester Hospital and $99,075 from Mount Auburn Hospital, for a total of $207,661 over a five-year period or $41,532 per year to support the following community prevention planning and health promotion programs and projects in the service areas of the Hospitals and benefit residents of the surrounding communities.

At Winchester Hospital:

1. $18,458 per year over five years for a total of $92,288 will be provided through Community Health Network Area 15 ("CHNA 15") to support a community planning process throughout the CHNA 15 communities.

   a. The project will involve broad community involvement, a transparent allocation process, defined outcome measures and an evaluation plan. The CHNA 15 project will be achieved by offering Planning Grants for communities to identify key health issues and through coalition building implement community wide plans to address these issues. CHNA 15 will award three Planning Grants a year for three years followed in subsequent years by three Implementation Grants to CHNA 15 communities that have developed successful plans.

   b. CHNA 15 will invite a representative of Winchester Hospital to participate in its steering committee.

2. $3,257 per year over five years for a total of $16,286 will be provided to Critical Mass, a statewide coalition to eliminate health disparities to support its activities as follows:

a. build a statewide membership, coordinate coalitions activities and develop training curricula and data collection methodologies,

b. organizational support to community/CHNA efforts to eliminate health disparities through capacity building, training and data collection.

CHNA 15 and Critical Mass, in consultation with the Department's Office of Healthy Communities ("OHC"), will provide an annual report to Winchester Hospital and the Department/OHC regarding the disbursement of funds contributed by Winchester Hospital. The annual report shall include a summary of the programs to which the funds have been applied and outcome measurement data for each program. This report will be issued no later than 90 days following the end of each 12-month period following the DoN Project implementation date, Winchester Hospital will disburse the funds to the fiscal agent(s) designated by CHNA 15 and Critical Mass.

Winchester Hospital will notify the OHC at least two weeks prior to the expected DoN project implementation date. The first payment will be due and payable not less than 30 days following the actual project implementation. Winchester Hospital will also file all reports as required by the Department.

<u>At Mount Auburn Hospital</u>:

1. $13,000 each year for five years or $23,333 each year for three years (to be decided by Community Health Network Area 17 "CHNA 17") for a total of $70,000 to target and to address public health concerns and health care needs of the most vulnerable populations in the area – Cambridge, Somerville, Watertown, Arlington, Belmont, and Waltham.

a. CHNA representatives, including Mount Auburn Hospital Community Benefits, local Department of Public Health Officials, and members of community organizations, will determine substantive areas for funding, conduct a competitive bid process, evaluate proposals, and determine recipients. All six communities should be involved and represented in aspects of this process.

b. As requested by the CHNA, Mount Auburn Hospital will act as fiscal conduit in the disbursement of funds to community organizations.

2. $29,075, the remaining funds will be divided between two projects.

a. Continuation of smoking cessation groups – a seven week program, offered four or five time per year. Smoking cessation programs are the number one request for community service in the hospital service area and these groups have been effective in helping residents stop smoking and stay smoke free.

b. A small amount of funding will be made available to the Waltham community and Joseph M. Smith Community Health Center to supplement funding for doula services targeted at newly immigrated Latina women.

CHNA 17, in consultation with the Department's OHC, will provide an annual report to Mount Auburn and the Department/OHC regarding the disbursement of the funds contributed by Mount Auburn Hospital. The annual report shall include a summary of the programs to which the funds have been applied and outcome measurement data for each program. This report will be issued no later than 90 days following the end of each 12-month period following the DoN Project implementation date.

Mount Auburn Hospital will notify the OHC at least two weeks prior to the expected DoN project implementation date. The first payment will be due and payable not less than 30 days following the actual project implementation date. Mount Auburn Hospital will also file all reports as required by the Department.

5. With regards to its interpreter service, Mt. Auburn/Winchester shall:

<u>At Winchester Hospital</u>:

- Translate basic patient information documents into the primary languages and make them available to patients with LEP.
- Develop a structure and timeline to ensure the availability of face-to-face interpreting services in addition to the present telephonic services.
- Develop a reliable and valid system for the collection of self-reported race ethnicity information from patients.
- Submit the Annual Language Needs Assessment required by 105 CMR 130.1103 utilizing internal and external data. Involve community-based organizations in the assessment process.

<u>At Mount Auburn Hospital:</u>

- Develop a reliable and valid system for the collection of self-reported race and ethnicity information from patients.
- Submit the Annual Language Needs Assessment required by 105 CMR 130.1103 utilizing internal and external data. Involve community-based organizations in the Annual Needs Assessment.

A plan to address these interpreter service elements shall be submitted to OMH within 120 days of the DoN approval, and Mt. Auburn/Winchester shall notify OMH of any substantial changes to its Interpreter Services Program. Also, Mt. Auburn/Winchester shall follow recommended National Standards for Culturally and Linguistically Appropriate Services ("CLAS") in Health Care. In addition, Mt. Auburn/Winchester will provide annual progress reports to OMH on the anniversary date of the DoN approval.

Staff's recommendation was based on the following findings:

1. Mt. Auburn/Winchester proposed to establish a mobile Positron Emission Tomography (PET) service at Mt. Auburn and Winchester Hospitals through acquisition of a mobile, combination PET/Computerized Axial Tomography (CT) scanner which will be located at Mt. Auburn Hospital in Cambridge and the Family Health Center of Winchester Hospital located in Wilmington.

2. The project meets the requirements of the health planning process consistent with the Guidelines for Positron Emission Tomography (Guidelines).

3. Mt. Auburn/Winchester has demonstrated demand for the proposed PET/CT service, as discussed under the Health Care Requirements factor of the staff summary.

4. The project, with adherence to a certain condition, meets the operational objectives of the Guidelines.

5. The project meets the compliance standards of the Guidelines.

6. The recommended maximum capital expenditure of $4,153,223 (August 2003 dollars) is reasonable, based on a similar, previously approved project.

7. The revised and recommended incremental operating costs of $2,097,585 (August 2003 dollars) are reasonable for a PET/CT unit and related hospital construction to accommodate the unit.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit provisions of the Guidelines.

10. The project, with adherence to a certain condition, meets the community health service initiatives of the DoN Regulations.

11. The Mark R. Taylor Ten Taxpayer Group (TTG) registered in connection with the proposed project, but did not submit written comments or request a public hearing.

12. This project is one of three comparable applications filed by Lahey Clinic PET Services, LLC (Project No. 4-3A60), Southcoast Hospitals Group (Project No. 5-3A62), and Mount Auburn/Winchester Hospitals (Project No. 4-3A63). When considered alone, each of these three applications is capable of being approved, since each has demonstrated demand for PET/CT services. Therefore, a detailed comparability analysis was not undertaken since these three applications each meet all the review factors of the PET Guidelines.

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The meeting adjourned at 11:15 a.m.

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Paul J. Cote, Jr., Chair

LMH/lmh